DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
Center for Substance Abuse Prevention
Center for Substance Abuse Treatment

Strengthening Early Childhood Interventions by Integrating Behavior Health Services

Short Title: SESS Prototypes

Guidance for Applicants (GFA) No. SP-01-009
Part I - Programmatic Guidance

Application Due Date: **July 30, 2001**

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Agency

Department of Health and Human Services (DHHS), Substance Abuse and Mental Health Services Administration (SAMHSA).

Action

The Substance Abuse and Mental Health Services Administration (SAMHSA), through the support of its Center for Substance Abuse Prevention (CSAP), the Center for Substance Abuse Treatment (CSAT), and the Center for Mental Health Services (CMHS), announces the availability of Fiscal Year 2001 funds for cooperative agreements to "Strengthen Early Childhood Interventions by Integrating Behavioral Health Services" into customary early childhood service settings. [1]

Approximately $2.5 million will be made available for 7 awards. The average award will be $300,000 in total costs (direct and indirect). Funds will support a 90 day planning period, local intervention services that address the program goals, data collection utilizing locally selected elements of an established data set, preparation of the project reports, and participation in funder/grantee workgroups on project implementation, data generation and analysis.

Awards may be requested for 3 years. Annual continuation awards depend on the availability of funds and progress achieved.

Purpose

Funds are being made available to replicate in new settings the core intervention components (found in Appendix A) implemented under SAMHSA's Starting Early Starting Smart (SESS) initiative in order to confirm their value in new primary care sites, community health clinics or Early Head Start programs.

Program Goals

This program calls for applicants to address the following goals:

(1) To increase access to behavioral health services by confirming the value of integrating behavioral health services into settings that families and young children 0-3 use regularly and frequently.

(2) To replicate and disseminate the most successful approaches to intervening early in the lives of young children impacted by multiple family and social problems in established primary care sites, community based health centers and Early Head Start childhood settings.

(3) To augment the knowledge of integrating behavioral health services in these non-stigmatized and familiar settings serving families and young children, by continued study of the results of these efforts through a validated set of impact measures, to be selected by grantees.

(4) To incorporate into existing programs, SESS lessons learned, including strength based work with families and cultural competence practices.

[1] Behavioral health is defined as substance abuse prevention treatment and mental health services.

Target Population

This initiative is targeted to vulnerable and underserved populations (i.e., homeless, families in public housing, migrants, teen parents with young children (0-3), that are impacted by substance abuse, mental disorders, family disruption and violence; through service providers.

Who Can Apply?

Applications for this initiative may be submitted by domestic public and non- profit primary care organizations, community health clinics and Early Head Start programs (include certification or evidence of eligibility in Appendix 5).

Application Kit

The grant application kit has several parts. Part I is different for each GFA. Part II has general policies and procedures that apply to all SAMHSA grant and cooperative agreements. You will need to use both Parts I and II for your application.

This document is Part I. The application also includes the forms you will need (SF424 and PHS 5161) to complete your application. To get a complete application kit, including Parts I and II, you can call the National Clearinghouse for Alcohol and Drug Information (NCADI) at 1-800-729-6686, or download from SAMHSA site at www.SAMHSA.gov.

Where to Send the Application

Send the original and 2 copies of your grant application to:

SAMHSA Programs
Center for Scientific Review
National Institutes of Health Suite 1049
6702 Rockledge Drive MSC -7710
Bethesda, MD 20892-7710
***** Change the zip code to 20817 if you use express mail or courier service.
Please note:

1. Use application for PHS 5161-1
2. Be sure to type: "SP-01-009 SESS Prototypes" in Item Number 10 on the face page of the application form.

Application Date

Your application must be received by July 30, 2001.

Applications received after this date will be accepted only if they have a receipt date or proof-of-mailing date from the carrier no later than July 23, 2001.
Private metered postmarks are not acceptable as proof of timely mailing. Late applications will be returned without review.

Contacts for Further Information

For questions on *program issues*, contact:

Jocelyn Whitfield, M.S.
Office on Early Childhood
Center for Substance Abuse Prevention
Substance Abuse and Mental Health Services Administration
Rockwall II, Suite 1075
5600 Fishers Lane
Rockville, MD 20857
(301) 443-7816
E-Mail: Jwhitfil@samhsa.gov

For questions on *grants management issues*, contact:
Edna Frazier
Division of Grants Management, OPS
Substance Abuse and Mental Health Services Administration
Rockwall II, 6th floor
5600 Fishers Lane
Rockville, MD 20857
(301) 443-6816
E-Mail: *efrazier@samhsa.gov*

Cooperative Agreements

These awards are being made as Cooperative Agreements because they require substantial involvement of Federal staff.

Role of Federal Staff:

Provide technical guidance and assistance to sites to help them achieve program goals. To support this replication effort, SESS Peer to Peer consultation[2] will be made available to assist new grantees with adapting SESS interventions and integrating them into their existing settings.

Monitor and review program progress including conducting site visits as needed.

Supply several SESS validated evaluation measures that new grantees can select, so that appropriate multi-site evaluation strategies can be employed, and early SESS findings reassessed.

Collect evaluation data, and progress reports, evaluate with grantees the project outcomes, and disseminate results.

Role of Awardees

Adapt a specific intervention approach based on the original SESS intervention components "The Modified Version of Key Principles in Providing Integrated Behavioral Health Services for Young Children and their Families: The SESS Experience" found in appendix A.

Collaborate with SAMHSA staff in project implementation and monitoring, technical assistance and evaluation.

Provide common data tapes, and supporting documentation.

Provide SAMHSA performance data required for Government and Results Act (GPRA), and other data reporting requirements.

Participate in Steering Committee composed of new SESS grantees.

Role of Program Coordinating Center (A separate coordinating center will be funded by SAMHSA at a later time.**)** This center will:

Provide ongoing overall study coordination including monitoring, coordination, collection, and management of data

Provide training in common

[2] Peer to Peer consultation is based on the concept of peer learning, which can be defined as a process by which providers, families, researchers, evaluators share strategies, experiences, knowledge, and skills with new grantees.

procedures, distributions of common materials, and secondary analysis of data.

Maintain data in a fully documented manner that will make it accessible to others for further analyses.

Conduct cross-site analyses of Cooperative Agreement sites and a comparative analysis of data and findings made available by the Program Coordinating Center of the first generation of SESS with the data and findings from the current SESS Cooperative Agreement sites.

Assume primary responsibility for assisting grantees with the identification of common data measures across awardees.

Help the steering committee develop policies on data access, sharing, publication and dissemination.

Provide coordination, scientific support and strategic and operational advice to the awardees.

Meet within 45 days of award with Government Project Officer(GPO) regarding scope of evaluation work and program implementation.

Logistics for awardee meetings.

Provide final data analyses report and findings, summarizing information from all sites, which includes methodology, analyses, findings, lessons learned and recommendations to the field.

Funding Criteria

Decisions to fund a grant announcement are based on:

1. The strengths and weaknesses of the application as identified by the Initial Peer Review Group and approved by the CSAP National Advisory Council

2. Availability of funds.

3. Overall program balance in terms of geography, and race/ethnicity of target population.

Post Award Requirements

1. Reports:
   Quarterly reports for year 01
   Semi-annual reports for years 02-03
   Final evaluation report documenting accomplishments and outcomes.
   Data Tape
   Publication Agreement
   Participation in technical assistance focused on fidelity of replication
   Participation in data analysis and evaluation workgroups

Background

The Need for Integrating Behavioral Health Service Interventions in Primary Care and Early Childhood Settings for Young Children (0-3)

In August 1997, the Substance Abuse and Mental Health Services Administration (SAMHSA) in collaboration with Casey Family Programs, funded Starting Early Starting Smart (SESS). The program was designed to introduce a long-term strategy to reach families with young children 0-7, whose lives are impacted by substance abuse, domestic violence, family disruption and mental disorders. Behavioral Health Services

were brought to settings where the parents were already comfortable and seeking improved outcomes for their children.

Over the last three years, SAMHSA has studied the impact of SESS on these young children (birth to age seven) and their families, when behavioral health services were integrated into service settings that families were already using for their children (childcare and primary care). The core principles of this model require the integration of substance abuse prevention, substance abuse treatment, and mental health services into community-based, child-centered, family focused service settings that build on family strengths, use culture as a resource, and require collaboration and partnerships at various levels.

Family relationships are significant in shaping a child's life and impacting his/her social, cognitive, and academic development (Carnegie Corporation 1994). Impaired parental functioning caused by licit and illicit drugs, mental disorders, violence, and abuse, influences parental judgment and priorities, with the parent/caregiver becoming unable to provide the consistent care, supervision, and guidance that children need (The Child Welfare League, 1999). These influences are often seen first in young children who manifest behavioral disturbances during health care visits and childcare.

Parental substance abuse has been noted as one of the primary factors contributing to child maltreatment and neglect *(The Congress on Substance Abuse and Child Protection Report, 1999). The Children's Defense Fund in The State of America's Children, Yearbook 2000,* estimates that 3 million children were victims of child abuse and neglect, and that infants represented the largest proportion, almost 40 percent under age six.

In order for young children living in these difficult environments to attain healthy emotional development and stability, their parents/caregivers must be able to access family supports, parenting education, and behavioral health services.

Detailed Information on What to Include in Your Application.

For your application to be **complete and eligible**, it must include the following in the order listed. Check off areas as you complete them for your application.

1. FACE PAGE

Use Standard Form 424. See Appendix A in Part II for instructions. In signing the face page of the application, you are agreeing that the information is accurate and complete.

2. ABSTRACT

In the first 5 lines or less of your abstract, write a summary of your project that, if funded, can be used in publications, reports to Congress, or press releases. Your total abstract may not be longer than 35 lines.

3. TABLE OF CONTENTS

Include page numbers for each of the major sections of your application and for each appendix.

4. BUDGET FORM

Standard Form 424A. See Appendix B in Part II for instructions.

5. PROJECT NARRATIVE AND SUPPORT DOCUMENTATION

These sections describe your project. The Project Narrative is made up of Sections A through E. More detailed information of A-E follows #10 of this checklist. Sections A-E may not be longer than 25 pages.

Section A- Need for Project

Section B - Project Plan (Design)

Section C- Project Evaluation

Methodology, data collection, analysis and performance monitoring. Select evaluation measures previously validated by SESS described in Appendix A.

Section D- Project Management, Implementation Plan, Organization Staff, Equipment/ Facilities, and Other Support.

Section E- Not required

There are no page limits for the following sections, except for Section H, the Biographical Sketches/Job Descriptions.

Section F- Literature Citations

This section must contain complete citations, including titles and all authors, for any literature you cite in your application.

☐ **Section G-** Budget Justification, Existing Resources, Other Support

Fill out sections B, C, and E of the Standard Form 424A. Follow instructions in Appendix B, Part II.

NOTE: Although the budget for the proposed project is not a review criterion, the Review Group will be asked to comment on the budget after the merits of the application have been considered.

☐ **Section H**- Biographical Sketches and Job Descriptions

-- Include a biographical sketch for the project director and for other key positions. Each sketch should not be longer than **2 pages**. If the person has not been hired, include a letter of commitment with the sketch.

-- Include job descriptions for key personnel. They should not be longer than **1 page**.

-- ***Sample sketches and job descriptions are listed in Item 6 in the Project Narrative section of the PH S 5161-1.*** Agencies (SSAs). Please refer to Part II.

Section I- Confidentiality and SAMHSA Participant Protection (SPP)

The seven areas you need to address in this section are outlined after the *Project narrative Section A-E Highlighted* section of this document.

6. APPENDICES 1 - 5

Use only the appendices listed below.

Don't use appendices to extend or replace any of the sections of the Project Narrative (reviewers will not consider these).

Don't use more than **30 pages** (plus all instruments) for the appendices.

Appendix 1:

Letters of Coordination and Support including any preexisting memoranda of agreement.

Appendix 2:

Selected data collection instruments and the interview protocols (see the Appendix A).

Appendix 3:

Copy of Letter(s) to the Single State Agency

Appendix 4:

Sample Consent Forms

Appendix 5:

Evidence of Eligibility (certifications, etc.)

7. ASSURANCES

Non-Construction Programs. Use Standard form 424B found in PHS 5161. Memorandum of Understanding (MOU) of an ongoing collaboration.

8. CERTIFICATIONS

9. DISCLOSURE OF LOBBYING ACTIVITIES

SAMHSA's policy does not allow lobbying.

Please see Part II for lobbying prohibitions

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10. CHECKLIST

See Appendix C in Part II for instructions.

Narrative– Sections A Through D Highlighted

Your application consists of responding to sections A through I. Sections A through D, the project narrative parts of your application, describe what you intend to do with your project. Below you will find detailed information on how to respond to sections A through D.

Sections A though D may not be longer than 25 pages.

A review committee will assign a point value to your application based on how well you address these sections.

The number of points after each main heading shows the maximum points the review committee may assign to that category.

Reviewers will also be looking for plans to address cultural competence.

Points will be deducted from applications that do not adequately address the cultural aspects of the review criterion.

Section

A: Need for the Project

(25 points)

This section of the application should**:**

Describe the current status of your early childhood intervention efforts, program emphasis and the numbers of children 0-3 you serve, including those with special needs, fetal alcohol syndrome, etc.

Describe the need for the SESS behavioral health interventions focused on families raising young children (0-3) in the community. Include local or regional needs assessment data on family violence and disruption, mental disorders, substance abuse and related information.

Describe the target population in terms of race, ethnicity, age and gender, or other special population features.

Identify the specific approach to SESS core interventions that you have selected for replication, based on those described in the cited paper found in Appendix A. Describe how you will adapt it; address the particular opportunities and circumstances in your organization and community that have shaped your replication service design**.**

Provide a brief logic model discussing the logic behind the SESS intervention approaches you have selected and how they will meet the particular needs for services in your community. Include intended short term outcomes and identify case management or care

coordination practices to be used to connect young children and families to the services.

Describe the preexisting partnerships, such as those with child welfare agencies, that you will draw on to integrate behavioral health services into customary early childhood settings and strengthen early intervention work in these settings.

Section B: Project Plan (Design)

(30 points)

This section of the application should:

Describe critical activities that will take place during the 90 day planning period. Include new collaborative arrangements, multi-disciplinary training activities, strategies to assure family participation, and outline program implementation steps.

Estimate the number of children, ages 0-3, and families that will receive integrated behavioral health services. Describe approaches you will use to engage and sustain families in these activities. Indicate what incentives you will use to retain client family members for ongoing participation in your program evaluation measures.

Provide plans to resolve potential recruiting problems and plans to obtain as much data as possible on project drop-outs.

Describe service and dosage.

Specify how replication fidelity for core project concepts and interventions will be maintained in the adaptation of the chosen intervention.

Describe how the target population will participate in planning and implementing the SESS project.

Describe cultural appropriateness of the program for the targeted population and program modifications that are planned. Present clear details on the process by which these modifications will be documented and implemented.

Describe your plan for sharing your activities and results with other federal projects similar to your own.

Section C: Methodology, Data Collection, Analysis and Performance Monitoring

(35 points)

This section of the application should:

Demonstrate how the measures selected from the validated SESS data set will be used and implemented. The SESS data set consists of client based data (collected with suitable confidentiality for both children and caregivers). Present a program evaluation plan to determine the effectiveness of integrating behavioral health services and core SESS intervention components into the early childhood setting. Include any additional data elements you need to capture the processes and interventions you have organized.

Describe the strategies for data collection, processing, clean-up, control, confidentiality and security.

Section D: Project Management, Implementation Plan, Organization, Staff, Equipment/Facilities and Other Support

(10 points)

Provide a project management plan, including a time line, that displays each planned activity, the target date for completion, milestones, and the name of the person responsible for oversight coordination, or implementation. This information may be presented in a table.

Describe the capability and experience of the organization and collaborating agencies with similar projects and target populations. This experience must pertain to the delivery of early childhood intervention, behavioral health, or evaluation services in early childhood service settings.

Describe the proposed staffing plan that includes staffing patterns (e.g., rationale for percent of time for key personnel and consultants).

Include a description of the qualifications and relevant experience of the Project Director, other key staff, the proposed consultants and/or subcontractors. This experience must pertain to the provision of family centered, strength-based behavioral health services for your target population, or other aspects of early childhood intervention, or relevant program evaluation experience.

Describe the cultural capabilities of the staff to ensure cultural competence in communicating with the target population and supporting the proposed intervention.

Document the staff's experience, familiarity, links and acceptance by the communities and the target population to be served.

Describe the relevant resources such as computer facilities and equipment as well as their location/facility in terms of space, accessibility (in compliance with the Americans with Disabilities Act) and environment.

Describe other resources, not accounted for in the proposed budgets, but necessary for the project.

Describe plans for securing resources to sustain the project once federal funding is terminated.

Confidentiality and SAMHSA Participant Protections (SPP)

You must address 7 areas regarding confidentiality and SAMHSA participant protection in your supporting documentation. However, no points will be assigned to this section.

This information will:

reveal if the protection of participants is adequate or if more protection is needed.

be considered when making funding decisions.

Some projects may expose people to risks in many different ways. In Section I of your application, you will need to:

report any possible risks for people in your project,

state how you plan to protect them from those risks, and

discuss how each type of risk will be dealt with, or why it does not apply to the project.

The following 7 issues must be discussed:

Protect Clients and Staff from Potential Risks:

Identify and describe any foreseeable physical, medical, psychological, social, legal, or other risks or adverse effects.

Discuss risks which are due either to participation in the project itself, or to the evaluation activities.

Describe the procedures that will be followed to minimize or protect

participants against potential health or confidentiality risks. Be sure to list potential risks in addition to any confidentiality issues.

Describe plans to provide help if there are adverse effects to participants, if needed in the project.

Where appropriate, describe alternative treatments and procedures that might be beneficial to the subjects.

Describe the target population(s) for the proposed project. Include age, gender, racial/ethnic background. Address other important factors such as homeless youth, foster children, children of substance abusers, pregnant women, or other special population groups.

Explain the reasons for using special types of participants, such as pregnant women, children, institutionalized or mentally disabled persons, prisoners, or others who are likely to be vulnerable to HIV/AIDS.

Explain the reasons for including or excluding participants.

Explain how you will recruit and select participants. Identify who will select participants.

Absence of Coercion:

Explain if participation in the project is voluntary or required. Identify possible reasons why it is required. For example, court orders requiring people to participate in a program.

If you plan to pay participants, state how participants will be awarded money or gifts.

State how volunteer participants will be told that they may receive services and incentives even if they do not complete the study.

Data Collection:

Identify from whom you will collect data. For example, participants themselves, family members, teachers, and others. Explain how you will collect data and list the sites. For example, will you use school records, interviews, psychological assessments, observation, questionnaires, or other sources?

Identify what types of specimen (e.g., urine, blood) will be used, if any. State if the material will be used just for evaluation and research or if other use will be made. Also, if needed, describe how the material will be monitored to ensure the safety of participants.

Provide in Appendix 2, "Data Collection Instruments/Interview Protocols," copies of all available data collection instruments and interview protocols that you plan to use.

Privacy and Confidentiality:

List how you will ensure privacy and confidentiality. Include who will collect data and how it will be collected.

Describe:

-How you will use data collection instruments.

- Where data will be stored.

- Who will or will not have access to data.

- How the identity of participants will be kept private. For example, through the use of a coding system on data records, limiting access to records, or storing identifiers separately from data.

NOTE: If applicable, awardees must agree to maintain the confidentiality of alcohol and drug abuse client records according to the

provisions of Title 42 of the Code of Federal Regulations, Part II.

Adequate Consent Procedures:

List what information will be given to people who participate in the project. Include the type and purpose of their participation. Include how the data will be used and how you will keep the data private.

State:

- If their participation is voluntary.
- Their right to leave the project at any time without difficulty.
- Risks from the project.
- Plans to protect clients from these risks.

- Explain how you will obtain consent for young children , the elderly, people with limited reading skills, and people who do not use English as their first language to participate in the project.

  Note: If the project poses potential physical, medical, psychological, legal, social, or other risks, you should get written informed consent.

- Indicate if you will get informed consent from participants or from their parents or legal guardians. Describe how the consent will be documented. For example: Will you read the consent forms? Will you ask prospective participants questions to be sure they understand the forms? Will you give them copies of what they sign?

- Include sample consent forms in your Appendix 4, titled "Sample Consent Forms." If needed, give English translations.

  Note: Never imply that the participant waives or appears to waive any legal rights, may not end involvement with the project, or releases your project or its agents from liability for negligence.

- Describe if separate consents will be obtained for different stages or parts of the project. For example, will they be needed for both the treatment intervention and for the collection of data. Will individuals who do not consent to having individually identifiable data collected for evaluation purposes be allowed to participate in the project?

Risk/Benefit Discussion:

- Discuss why the risks are reasonable compared to expected benefits and importance of the knowledge from the project.

Appendix A

A Modified Version of

Key Principles in Providing Integrated Behavioral Health Services for Young Children and their Families:
"The SESS Experience"

SESS study sites collectively identified a broad conceptual framework for designing an early intervention model for integrating behavioral health services in early childhood and primary care settings serving settings serving families and young children at risk for substance abuse and mental health disorders. The following descriptions of the core SESS program elements and represent a composite of philosophical principles and structural components of the most successful SESS interventions and evaluation approaches. Evaluation options are presented briefly that cover several major outcome domains of potential interest to early intervention programs, including child development, caregiver/family functioning, family health and safety, service integration, and other associated outcomes. In addition, information regarding a sampling of potential measures within each domain is provided as a starting point for developing a local evaluation plan. These descriptions have been obtained from a monograph authored by SESS study sites called Key Principles in Providing Integrated Behavioral Health Services for Young Children and their Families: The Starting Early Starting Smart Experience " can be found on the SAMHSA website (www. SAMHSA.gov).

The major goal of this early intervention service integration approach is to increase access and utilization of needed behavioral health services by families with young children. Behavioral health services are defined in the context of the SESS as substance abuse prevention, substance abuse treatment, mental health services, and family/parenting services. This includes the provision of family support, advocacy, and care coordination that addresses medical, educational and basic needs, as well as coordinates behavioral health and other services for families. There is no single, universally-imposed SESS intervention protocol, but rather each program should be tailored to the overall program plan to the specific population, setting, and community served. The SESS model should be comprehensive and responsive across time, culturally competent, strength-based, and family-centered and at a minimum, should have available ongoing screening, assessment and

referral options. In addition, some direct intervention activities in each area should be offered, although programs may choose from a progression of options that vary in intensity and duration depending on the needs of the target population and setting. Applicants must include some of the following SESS program elements and service components from the following categories in their grant proposal.

Behavioral Health Service Components: Core Behavioral Health Service Components include Substance Abuse Prevention, Substance Abuse Treatment, Mental Health Services, and Family/Parenting Services.

1. **Substance Abuse Prevention**: Substance Abuse Prevention activities in SESS programs may include: educational activities and curriculum that target children, adults, and families, to increase awareness of substance abuse and its consequences and encourage adaptive coping mechanisms to deal with stress; the encouragement and development and maintenance of positive and appropriate family and peer support, and the distribution of multimedia education materials. Assessments may include evaluation of both young children and caregivers' knowledge and exposure, family history, and personal experiences with ATOD (alcohol, tobacco, and other drugs). Family focused prevention efforts are most effective when they focus on protective factors such as increasing social support, and parental self-concept and satisfaction.
2. **Substance Abuse Treatment Services:** Substance Abuse Treatment Services are more applicable to adult caregivers in the family and should be well delivered, tailored and coordinated to meet the needs of family members. Collaborative partnerships with specialized agencies are essential, if program sites do not provide substance abuse treatment directly. Comprehensive and ongoing assessment of substance abuse, as well as the potential for underlying mental health diagnoses that are associated with drug use should be prioritized. Evaluation should provide a detailed assessment of the caregiver's personal history and patterns of ATOD use and treatment, beliefs, or perceptions of this behavior, and the ways in which the activity has impacted daily functioning adaptation. Training of early childhood and primary health care staff regarding the awareness of

substance abuse to facilitate appropriate screening and referral of families is critical. Staff may also be member of the substance abuse treatment team, maintaining ongoing consultation with treatment center staff to monitor and support the client's progress and to assist in coordinating services.

3. **Mental Health Services**: Mental Health Services may be applicable to both adult caregivers and child(ren) in a family**.** Adult evaluation may include brief assessment of mental status, mental , emotional, or somatic symptoms, formal diagnosis, history of or current suicidal thoughts and actions, and current level of daily functioning. For young children, early routine developmental screening of cognitive, motor, social and emotional growth is important service that may lead to early intervention and amelioration of difficulties in many cases. Mental Health Services may also consist of: the training of early childhood and primary care staff regarding children and adult mental health; children intervention groups focusing on development of age appropriate social skills; conflict resolution, emotional development. In addition, study sites may provide on site adult mental health specialist to provide needed assessment and intervention to provide acute, short term counseling services on site or in the home of individuals,, couples, and families as well as on site child behavioral health specialist to offer services critical to prevention, identification, and early intervention of the child's behavioral problems. Referral to a more intensive, individual mental health services may be required to address more serious child behavioral attachment problems. Education / prevention family group sessions may be conducted on related mental health topics such as soothing techniques, crisis management, non violent problem solving, conflict resolution, domestic violence, awareness, communication skills , recognizing and coping with depression, and women's health.

4. **Family Support Services, Advocacy, and Care Coordination:** These services are delivered within the context of a central provider who is then supported by a more extensive multi disciplinary team. Multi disciplinary team members may include family members, child development specialists, physicians, nurses, educators, social workers, psychologists, health care providers, mental health providers, substance abuse specialists, family advocates and others. Using Family Advocates allows and encourages families to take responsibility for meeting their own needs by having parents identify and prioritize

their most pressing problems, educating families about accessing service systems, and inviting family participation in the multi disciplinary team and program planning. Families should be involved in all stages of program development, including planning, implementation, and evaluation. Family members will be able to provide ongoing insight into the reasons interventions are working well or ways to improve them. Family /Parenting services should include the evaluation of parenting beliefs, stressors, behavior, and need via formal testing and or staff observations on site and in the home environments. Evaluations in the home are especially useful because they provide a picture of the home and family environment and parent -child interaction in a more natural setting.

5. **Collaboration:** Collaboration among a range of stakeholders is imperative. Some examples of collaborative partners include family members, mental health providers, substance abuse treatment providers, youth services, educational settings, child welfare agencies, social service agencies, health care providers, criminal justice agencies, faith based service programs, and public health initiatives. The choice of collaborators and services should be based on local resources and the needs of the target population.

6. **Interagency Training:** Interagency training around common interests and needs can be particularly valuable. Training can provide an opportunity for dialog to explore common ground, including values. Interactive training with breaks and meals also facilitates the development of new relationships and refresh existing ones.

7. **Cultural Competence:** Families reflect cultural diversity in their values and beliefs, and in the views and expectations they have for themselves, their children, and their providers. Understanding diversity is particularly important when considering a family's perceptions of illness, wellness and health, child rearing practices, and developmental expectations for children. Staff must be knowledgeable about both mainstream parenting practices and beliefs from other cultural perspectives, and ideally will reflect the multilingual and multi cultural diversity of the families with whom they work. The Center for Substance Abuse Prevention has published guidelines for assessing cultural competence, which include consideration of organizational experience with the target population, training and staffing

issues, language, materials used in interventions, program evaluation methods and instruments, community representation in participatory planning, and the implementation process (CSAP, 2001). At the agency level, there should be a track record of positive involvement with the target population. Staff should be representative of or familiar with the community being served, and should receive training in gender, age, and cultural competence. Resources and services should be available in a multi-linguistic format appropriate to the target population, and materials used in interventions should be gender, age, and culturally relevant. In terms of evaluation, providers need to be aware of the limitations of screening and assessment tools and carefully select the most culturally relevant tools when assessing children and families from diverse cultural backgrounds. For example, appreciation for the cultural differences in parenting styles and in fostering developmental competencies in children must be taken into account when evaluating and interpreting children's behavioral and developmental outcomes. In order to facilitate program success and avoid pitfalls, interventions must be designed to honor and respect each family's traditions, values, and beliefs.

Program Evaluation

Similar to the flexible approach to selecting intervention components, the development of a program's logic model and evaluation strategies must be tailored to fit the specific program goals. This section is intended to serve as a guide for developing outcome evaluations. As in the approach described throughout, specific mandates regarding outcome domains and assessment tools are not made. Instead, examples of outcome indicators are provided to suggest potential domains and to guide agencies in selecting the key outcomes and measures appropriate to their specific interventions, settings and populations.

Potential Outcome Domains for Early Intervention Programs

1. Child Development: Given the general goal of early intervention to enhance child mental, motor, social, emotional, and behavioral development, most early intervention evaluations include measures in this domain, administered either to participating children or their caregivers. Measures of the child's general developmental status typically include evaluation of current mental and motor functioning during infancy, global cognitive and language processing skills

generally starting in toddlerhood, and school readiness indicators beginning with preschoolers. Social, emotional, and behavioral development is typically measured through observational and caregiver-report measures of functioning, which evaluate social-emotional regulation, behavior problems and competencies, and social skills. Within this domain, it is critical that the specific measures selected are culturally appropriate, especially with regard to age and language, while at the same time reflect the specific objectives of the program being delivered.

2. Caregiver/Family Functioning: Because children develop in the context of families, caregiver and family functioning is closely linked to child development and is a commonly targeted outcome domain for early intervention programs. Measures include assessments of caregiver behavioral health status, such as the level of current psychological symptoms and patterns of substance use and abuse. In addition, parenting role stress and skills are often targeted and measured with self-report inventories. Various observational rating systems and measures are also available to measure potential contributions of caregiver-child interaction, as well as the quality of the home environment to child developmental outcomes.

3. Family Health and Safety: This category captures the expectation that early intervention programs may affect child and adult health outcomes, broadly defined to include aspects of health status and health care utilization. In addition to general physical health status, some programs consider specific areas of family health and safety such as general social support, conflict communication styles, domestic violence, and the incidence of child abuse and neglect.

4. Service Integration: A final but primary outcome domain in a SESS early intervention model focused on integrated services includes some measure of client access, utilization and satisfaction with physical and behavioral health services. Within the context of evaluating this outcome, process data collection regarding the fidelity or adherence to the designed integrated intervention model is necessary. This may include collecting data on the types, duration, and dosage of services, as well as whether the interventions being provided match closely to what the program blueprint or logic model outlined.

5. Other Associated Outcomes: Several other family outcome domains can potentially be impacted by early intervention programs, depending on program emphases. Many times demographic or descriptive information about specific areas of interest can be collected and utilized in program evaluation. While longitudinal program evaluations typically consider these

outcomes for participating children as they make the transition to adulthood, some programs focus on this domain for caregivers.

6. Measuring Key Outcome Domains

The following illustrates a sampling of some possible measures of early intervention program. Within each domain, we list just some of the common measures used in early intervention studies. An individual program's intervention and logic model, community needs, and agency resources may differ and will help determine what can realistically be used.

Key Outcome Domains and Indicators: A Sampling of Potential Measures

Outcome Domains and Indicators	Potential Measures
I. Child Development	
A. Mental and Motor Development	
Global Cognitive Skills	
C. Language Processing Skills	
D. School Readiness Indicators	Academic Rating Scale of the Fall or Spring Kindergarten Questionnaire of the Early Childhood Longitudinal Study (ARS)
E. Behavioral and Emotional Development	
Caregiver/Family Functioning	

A. Caregiver Behavioral Health Status	Addiction Severity Index (ASI) (McLellan et al., 1990) Beck Depression Inventory (BDI) (Beck & Steer, 1987) Brief Symptom Inventory (BSI) (Derogatis & Spencer, 1999) CAGE (Cut down, Annoyed, Guilty, Eye opener) Questionnaire (a 4-item brief screener for alcohol/drug use) from the Health and Lifestyle Survey
Parenting Role Stress and Skills	Adult/Adolescent Parenting Inventory (AAPI) (Bavolek & Keene, 1999) Parent-Child Relationship Inventory (PCRI) (Gerard, 1994) SESS Parental Discipline Methods Interview (adapted from Webster-Stratton's Parenting Practices Interview and the Kansas Discipline Methods Questionnaire) Parenting Dimensions Inventory (Slater & Power, 1987) Parenting Practices Questionnaire (Strayhorn & Weidman, 1988) Parenting Stress Index (PSI) (Abidin, 1990)

Outcome Domains and Indicators	Potential Measures
II. Caregiver/Family Functioning (continued)	
C. Caregiver-Child Interaction	Nursing Child Assessment Satellite Training (NCAST) Feeding Scale (Barnard, 1994a) Nursing Child Assessment Satellite Training (NCAST) Teaching Scale (Barnard, 1994b) National Institute on Child Health and Development Scales (NICHD) (Early Child Care Research Network, 1993) Parent-Child Observational Guide (PCOG) (developed by V. Bernstein and the SESS Steering Committee's Parent-Child Interaction Workgroup)
D. Quality of Home and Caregiving Environment	

III. Family Health and Safety	
A. Child Health	SESS Physical Health Questionnaire – Infant and Child Versions
B. Caregiver Health	
C. Family Conflict Management and Communication	
D. Social Support	
E. Child Maltreatment	Child Abuse Potential Inventory (CAPI) (Milner & Wimberley, 1979) Verified Child Maltreatment and/or Injury Reports

IV. Service Integration	
A. Access, Utilization, and Satisfaction with Services	SESS Service Access, Utilization, and Satisfaction (SAUS) (data collection instrument will be made available on the SESS website)
B. Service Model Fidelity	Measures of dosage, duration, intensity and adherence to the program logic model, and/or practice protocols Consumer and staff satisfaction and needs surveys or focus groups

In conclusion, there are no absolute or perfect solutions to designing a SESS early intervention program, but this paper has set forth some general guiding principles, as well as valid options and choices to enable communities to begin the process of developing a tailored SESS model that can work best in the context of a particular setting, population, and community.